



**Statement for the Record
by the
American Federation of State, County and
Municipal Employees (AFSCME)
for the Hearing
on
Medicare Premium Support Proposals
Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
April 27, 2012**

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This statement is submitted on behalf of the 1.6 million workers and retiree members of the American Federation of State, County and Municipal Employees (AFSCME), for the hearing held April 27, 2012 on Medicare Premium Support Proposals.

AFSCME is proud of labor's historic role in the creation Medicare. It is an indispensable federal social insurance program. Medicare provides what commercial health insurance companies did not, would not, and could not; affordable, adequate health coverage for America's elderly population regardless of income or health status. Before the enactment of Medicare, only half the population age 65 and older had health insurance and, those who did have coverage, paid close to triple what younger people paid for premiums and other out-of-pocket costs.

Before we evaluate premium support proposals, it is important to briefly review Medicare's core purposes and how Medicare has successfully pooled our nation's resources to equitably meet an ongoing need for each generation.

Medicare Is Not and Should Not Be Like Commercial Insurance

Medicare and private plans may seem as being similar in that both allow individuals to go to a doctor and get medical treatment. The foundation and purpose of Medicare is profoundly unlike commercial health plans. As a social insurance plan, Medicare's purpose is to absorb and spread risk, serving individuals who may have costly and complex medical needs as well as the relatively healthy. Medicare unites the resources of the entire nation to shield one generation after another of older Americans and individuals with disabilities from financial ruin in the event of illness, injury or expensive chronic conditions. All American workers contribute to fund the program and reap the benefits of the program once they are eligible. No one is shut out because of health status or income. Medicare by design pays for all necessary medical care for beneficiaries. Medicare will pay claims without discriminating against an individual because of where they live, their history, their diagnoses or preferences. President Johnson's Medicare signing statement addressed the core American values at the heart of Medicare's financial and benefit design — individual dignity, fairness, and safeguarding the common good:

“No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young

families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts. And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.”

Private health insurance companies have a very different purpose and function. Their business interest is to avoid selecting individuals with medical needs in order to maximize profits. In short, insurance companies seek to avoid risk, not pool it.

Medicare Successfully Pools Risk to Deliver Guaranteed Benefits

The Budget for FY 2013 passed by the House of Representatives along party lines, calls for a radical restructuring of Medicare and a repeal of the Affordable Care Act (ACA). The justification for such changes is to reduce the deficit and to rein in the so-called “out-of-control” spending in Medicare and to save the future of Medicare. Analysis of data actually shows these justifications to be highly questionable.

Historically, Medicare per capita spending has grown a bit slower than the private sector’s. Medicare’s growth rate is remarkably low when it comes to health care costs per person.¹ Over the next decade, Medicare’s per beneficiary rate of growth is projected to be low, *in large part due to changes in the Affordable Care Act (ACA).*

The ACA promotes cost-efficient delivery of quality care under Medicare. The law taps into Medicare’s purchasing power to prompt providers, who are increasingly concentrated and can effectively drive up payments regardless of quality, to do more to control their costs.² It is important to highlight that none of the payment reforms affect Medicare’s guaranteed benefit packages. In fact, the law spells out loud and clear that the guaranteed benefits in Medicare Part A and Part B will not be reduced or eliminated as a result of changes to the Medicare program.

The ACA protects taxpayer and Medicare dollars against fraud in Medicare. In 2011, Medicare used the new ACA enforcement tools to recover nearly \$4.1 billion from individuals and companies who attempted to defraud seniors and taxpayers. In most cases, they charged Medicare for services never received by beneficiaries, or deliberately overcharged for services rendered.

The fiscal improvements in the ACA help Medicare to hold down premium increases for beneficiaries who are older and sicker than the non-Medicare population. The Congressional Budget Office (CBO) finds that Medicare premiums, currently estimated to be 11 percent lower than private insurance premiums for the same benefit package, will be about 30 percent lower by the end of the next decade.

Because the funding structure of Medicare – through payroll contributions, revenues and beneficiary cost-sharing – fluctuates with the economy, the surefire way to fortify the solvency of Medicare and address the deficit is to improve the economy. Creating jobs, closing corporate

¹ <http://www.urban.org/UploadedPDF/412544-Medicare-Medicaid-and-the-Deficit-Debate.pdf>

² *Ibid.*

tax loopholes and requiring the wealthiest Americans to pay their fair share will help Medicare and its beneficiaries.

Redesigning Medicare: Premium Supports

The need for Medicare to remain a refuge against financial ruin caused by the caprice of illness and disability rings as true today as it did nearly half a century ago when Medicare was created. Any proposal to redesign or structurally change Medicare should be able to affirmatively meet at least three criteria which are at the heart and soul of Medicare.

- 1) Does the proposal effectively spread risk and deliver guaranteed benefits of medically necessary care, regardless of an individual's medical condition?
- 2) Does the proposal effectively continue Medicare's core function of pooling resources to finance health coverage for seniors and individuals with disabilities?
- 3) Does the proposal effectively continue Medicare's core purpose of protecting beneficiaries and their families from financial ruin due to illness, disease or injury?

The House-passed budget which restructures Medicare into premium supports, cuts benefits, raises the age of eligibility and repeals the ACA, fails on all three criteria.

The budget plan replaces Medicare's guarantee of health coverage and set premiums. Instead, future retirees would be given a flat payment, or voucher, that beneficiaries would use to purchase either private health insurance or traditional Medicare. The voucher is designed to lose value over time so that more and more of the cost of coverage (premiums and cost sharing) would be shifted to beneficiaries. Because the median income of Medicare households is about \$25,000 a year, and most spend three times as much of their budgets on out-of-pocket health expenses compared to non-Medicare households, many retirees would find that coverage is unaffordable at higher costs.

According to the CBO, the premium support or voucher proposal will increase costs for Medicare beneficiaries by more than \$2,200 per beneficiary starting in 2030 and increasing to \$8,000 in 2050.

Offering both private plans and traditional Medicare uses the promise of choice to disguise the diminishment of Medicare's function to deliver guaranteed benefits and pool resources and spread risk. The private plans, like the private Medicare Advantage plans, will still cherry-pick healthier and less costly enrollees and leave Medicare with a less healthy pool of beneficiaries. Over time, traditional Medicare will become less affordable, causing costs to rise for sicker and older beneficiaries.

There is no guarantee that the premium support or voucher would cover the cost of Medicare at the start or over time. Currently, Medicare premiums are the same, regardless of where a beneficiary resides in our nation. There is no guarantee that the premiums will be adequate to cover a private Medicare plan regardless of location.

The private plans would not be required to provide the guaranteed benefits under Medicare. The private plans would only be required to provide the actuarial equivalent of the benefits under traditional Medicare. Again, the history of beneficiary abuse and exploitation by

Medicare Advantage private plans illustrate the dangers for health and financial security of the sickest and oldest beneficiaries.

Conclusion

Medicare is an amazing success story – providing health and financial security to millions of Americans, even during the worst economic crisis since the Great Depression. AFSCME opposes the House-passed budget’s restructuring of Medicare because it would expose older Americans and their families to financial ruin caused by the caprice of illness and disability. It would allow sick and older seniors and individuals with disabilities to be denied the promise of modern medicine because of income and health status. In short, we oppose the premium support or voucher proposal because it ends Medicare, as we know it.